South Carolina Association of Children's Homes and Family Services

December 14, 2011

The Honorable G. Murrell Smith, Jr.
House of Representatives
420B Blatt Building
Columbia, South Carolina 29201

Re: Department of Health and Human Services

Dear Representative Smith:

In reviewing your agenda for the upcoming meeting of the Healthcare subcommittee on December 15, comments were solicited regarding the above captioned agency. We recognize the enormity of the deficit reduction problem HHS faced last year. Mr. Keck has been impressive in his critical thinking about health outcomes.

The Association represents 50 members who deliver statewide services to children and families. SCACHFS is a non-profit 501(c)(3) membership organization composed of private providers. The Duke Endowment is an honorary member. Private sector members offer a continuum of services, including: emergency shelter care, residential treatment, group care intensive, group care intermediate and low management residential care, therapeutic foster care, supervised independent living, wrap-around and other family services. Our mission is to serve as a united force to improve the conditions for children and families in South Carolina and to assist member agencies in the accomplishment of their missions.

The Association has a unique identity in the state and is actively involved with policy and program development as it relates to our members and their needs. Our members raised just under $20M last year to undergird the state run foster care/child welfare system. Our members employ thousands of people in South Carolina. I have attempted to summarize the issues that are important to the SC Association of Children's Homes and Family Services (SCACHFS).

Background

1. Our states' private child serving organizations have been in constant turmoil for over 5 years. After concerns about how Georgia operated certain programming financed with federal Medicaid dollars, the former Kerr administration at DHHS removed federal financial participation from the rates paid to *group homes*, resulting in the need for $39M to be appropriated over three years by the General Assembly. The Institutions for Mental Diseases (IMD) policies for South Carolina child serving organizations remain largely unresolved for providers of group care. Our Association conducted over 20 hours of research to distill how other states and federal agencies defined IMD status for group care providers in excess of 16 beds. This information was provided to HHS and all other state

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child placing agencies. We also developed, with state agency input, a review tool for use in determining the level of risk for a program to be considered an IMD. We need guidance from HHS, or perhaps the General Assembly, on compliance that can refine and clarify a definition of IMD for our state.

2. HHS, in consultation with CMS, unbundled certain services including *therapeutic foster care* to create discreet services and discreet rates for each service through what is referred to as the Rehabilitative Behavioral Health State Plan Amendment. The burden for Medicaid compliance in delivering therapeutic foster care services now rests unrealistically on the foster parent, who must document to the level of professional standards that even credentialed staff are often unable to meet. This is having a chilling effect on recruitment and retention of foster parents – the very last thing this state wants to do.

   In the SPA referenced above, private providers were held to higher credentialing standards by HHS than state agency personnel. Providers then had to hire persons with more credentials. This added to the cost of administration without an offset to providers through the rate infrastructure.

   In addition, providers will be required to be accredited in order to bill for these services effective July 1, 2012. SCACHFS supports accreditation, but this is another unfunded mandate for the private sector, and many small provider organizations are unable to get funding to secure national accreditation. For those who are seeking accreditation, the process can take from 12-18 months. Our Association requests consideration of extending the deadline for those who have made a bona-fide effort to start the process after they located funding.

- We await a decision on whether our faith based providers which use EAGLE as their national accrediting authority can bill Medicaid after 7/1/12. In a state like South Carolina, with its roots in faith based institutions, it is hard to imagine that a faith-based accrediting authority might not be "acceptable." We need an answer now, not 6 months from now, when it will be too late to obtain accreditation.

The following observations are provided to the subcommittee.

1. We recently submitted comments regarding the provision of targeted case management (TCM) services in South Carolina. There has been no response to our comments, nor has the draft SPA been shared with our organization, but we believe that the private sector organizations can – and should – be able to deliver and bill for TCM services, and the service should not be delivered only by state agencies. We are aware that state agencies are dependent upon this revenue.

2. It appears that state agencies will have to create a qualified provider list in the future (QPL) but it is certainly possible that the individual agency could set the "qualification" standards higher for private providers than they have in their state agency ranks. We oppose such an action.

3. Our Association, on behalf of its therapeutic foster care (TFC) agencies, has asked for information on re-bundling the former service, assured many times that the decisions were related to backlogs in the data analysis. HHS representatives agreed last week to

look at the data. We need some commitment from the agency to work through this, and other compliance issues.

4. Our Association has requested assistance with evaluating a transition to D.C. 0-3R codes from DSM codes for children ages five years and under. We were advised to "provide research to DHHS" to convince decision-makers that such a conversion was the right thing to do. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised (D.C. 0-3R) is a more appropriate tool than the DSM IV to use in diagnosing children under the age of 3 years.

   Many states have incorporated D.C. 0-3R codes into their Medicaid billing systems, while others have developed crosswalks to the DSM codes that are already used for billing. Examples of these crosswalks have been shared with DHHS staff. In a meeting this week, HHS agreed to temporarily continue use of V coding for longer than six months for this age cohort as long as treatment needs were being pursued. There appears to be some paranoia that making a simple change in codes will "open the gates" for more children to enter the system. We need to be more focused on what is right for children's care and treatment. HHS staff could contact the fourteen other state Medicaid programs that moved to D.C. 0-3 coding and do some research.

5. We have requested, as have others, meetings to discuss PRTF all inclusive rates and have been told to wait until after hearings have been completed on the Program Integrity reviews. We also know that DHHS staff have met with other state officials regarding this level of care, and we ask that private sector viewpoints be considered BEFORE decisions are made that impact the private providers.

   Providers report seeking compliance guidance from HHS employees without any – or full – response. In addition, we must address the rates in these treatment programs, as some of these facilities report, for example, having to pay for human growth hormone injections (estimated at $3,500 per month according to our information) or other very high cost conditions out of the all inclusive rate.

   When Qualis was under contract to monitor compliance for HHS, providers were supplied with the oversight/monitoring tool. Providers report that contacts with HHS on compliance and monitoring offer conflicting responses depending upon the staff you interact with. Interpreting the standards is difficult and each provider seems to interpret things differently. We need clarity on compliance issues, and we should be able to expect that our state officials are there to help us comply.

6. We need assistance in remediating a problem for some providers whose legitimate claims eject because two RBHS providers are billing for the same beneficiary in unusual circumstances. We have been told these billing problems are not as prevalent as they once were, but there needs to be a real solution as RBHS providers increase in numbers.

7. In recent letters sent to providers by Ms. Jeanne Carlton, Division Director, she reminded participants who bill for behavioral health services that full accreditation status is required by July 1, 2012. However, we have certainly had verbal agreements over the last two years that EAGLE is a national accrediting body for faith based organizations and would be an acceptable accreditation process. However, EAGLE was not listed among

the ones enumerated in her notification. This omission has caused deep concerns among our faith-based organizations who deliver services to children.

In summary:

- We need fewer bureaucratic changes and more compliance assistance as our child serving organizations try to meet the needs of children and families in South Carolina.
- Invite private providers to the table for their expertise and input before any further state plan amendments or policy decisions are made and put in place a management infrastructure to handle provider concerns and questions.
- We encourage and need more legislative oversight of reforms and changes impacting child serving organizations. Many states have a legislative process in place whereby the General Assembly signs off on state plan amendments. This is something worth evaluating.

I have set an appointment to meet with Mr. Keck in early January 2012 to discuss these and other issues, but wanted to be sure to provide our comments to the Subcommittee. I regret the comments may, at times, be very technical. We think DHHS could do a better job of reaching out to the Association and our fifty (50) members, and we hope our partnership will grow to the extent that our input is solicited **prior** to the development of policies and procedures. Without doing so, compliance may not be achieved and outcomes for children could suffer.

Kindest Personal Regards,

Paula M. Fendley

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